

MIAMI LIGHTHOUSE HEIKEN CHILDREN'S VISION PROGRAM

601 Southwest 8th Avenue

Miami, FL 33130

Phone: (305) 856-9830 Fax: (305) 856-9840

www.miamilighthouse.org

Dear Parent/Guardian,

The Miami Lighthouse Heiken Children's Vision Program is offering comprehensive eye exams and glasses, if necessary, for students who failed the vision screening and qualify to participate.

The comprehensive eye exam includes the use of eye drops to dilate the pupils, which allows the doctor to get the most accurate eye health information and glasses prescription. The drops are safe to use, and severe adverse reactions are extremely rare. Light sensitivity and blurry near vision are normal for 4-6 hours following the exam, that may be performed at your child's school.

This program is available at no cost to you or to your child's school. However, if during eligibility verification by the Miami Lighthouse Heiken Children's Vision Program, your child is found to be enrolled in a participating vision insurance plan, you consent to those benefits being used for the eye exam and the glasses, by signing the back of this form.

If you **DO NOT** want your child to participate in this program, please print your name and your child's name and sign below.

I _____, **DO NOT** want my child
Print Parent's Name

_____, to participate in this program.
Print Student's Name

Parent Signature

Date

If you have any questions please contact your child's school counselor or Nashieli Garcia, Program Manager for the Miami Lighthouse Heiken Children's Vision Program at 786-362-7527.

School _____ Grade _____ Teacher _____

Student's name _____ M / F Student's DOB _____

Address _____ City _____ Zip code _____

Home phone _____ Parent's day phone _____

Parent/Guardian name _____

Ethnicity (Circle One): African American Asian Hispanic Native American White (non-Hispanic) other

Does your child wear glasses? Yes _____ No _____ Broken _____ Lost _____

Has your child seen an eye doctor in the past year? Yes _____ No _____

Please list any eye problems your child has: _____

Please list any health problems your child has: _____

Please list any medication or eye drops your child uses: _____

Please list any seasonal or medication allergies your child has: _____

Does your child have any special needs/developmental delays? Yes _____ No _____

Has your **child** had any of the following:

YES NO

- | | | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye surgery / Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye turn / Strabismus / Lazy eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision therapy / Eye patching |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Other |

Has anyone in your child's **family** had any of the following:

YES NO

- | | | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye turn / Strabismus / Lazy eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Blindness |
| <input type="checkbox"/> | <input type="checkbox"/> | Macular Degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell |
| <input type="checkbox"/> | <input type="checkbox"/> | Other |

Please explain any "YES" answers from above: _____

Consent for eye examination –By signing below, I authorize my child to have a full eye examination **including** dilation.

Notice of privacy practices –By signing below, I understand that the Notice of Privacy Practices for the Miami Lighthouse Heiken Children's Vision Program is available for review if I should request a copy via phone at 305-856-9830.

Mutual exchange of information – By signing below, I authorize the mutual release of information between the Miami Lighthouse Heiken Children's Vision Program and Miami-Dade County Public Schools to release any and all optometry and ophthalmology medical reports on my child to participating program providers.

Claims - If your child is covered under an insurance plan, the Miami Lighthouse reserves the right to obtain information to submit for payment for such service to the insurance company.

Parent Signature: _____ Date: _____